COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
MEDICAID PROGRAM

CHILDREN'S MENTAL HEALTH PROGRAM
PRE-RELEASE REFERRAL

This form is used for pre-release planning and placement purposes for children in psychiatric residential treatment facilities. Section A is to be completed by the Transitional Services Coordinator (TSC). Section B is to be completed by the Eligibility Worker (EW). The EW should review the child's Medicaid eligibility based on the proposed placement and return the form to the TSC as soon as possible, but no later than 30 days after receipt of this referral. EW must p*lace a copy of this referral form in the recipient's case record.* ***The TSC will return the form to the EW if the child is discharged from the facility.***

_____	_____
TRANSITIONAL SERVICES COORDINATOR	***LDSS ELIGIBILITY WORKER***
_____	_____
AGENCY	***AGENCY***
_____	_____
ADDRESS	***ADDRESS***
_____	_____
(___)_____ (___)_____	**(___)_____ (___)_____**
PHONE FAX	**PHONE FAX**

A. CHILD'S INFORMATION: (TO BE COMPLETED BY TSC.)

NAME: _____ MEDICAID #: _____

SSN: _____ BIRTHDATE: _____

❑ PROPOSED DISCHARGE DATE: _____ ❑ *DATE DISCHARGED TO COMMUNITY: _____

COMMUNITY PLACEMENT WITH:

❑ PARENT(S) ❑ OTHER RELATIVE ❑ GUARDIAN ❑ FOSTER CARE

NAME: _____ PHONE #: (____)_____

ADDRESS: _____

_____

DATE MAILED/FAXED: _____TO ELIGIBILITY WORKER.

*DATE MAILED/FAXED: _____TO ELIGIBILITY WORKER.

B. MEDICAID DETERMINATION FOR PROPOSED PLACEMENT: (TO BE COMPLETED BY EW.)

❑ CHILD WILL REMAIN ELIGIBLE FOR MEDICAID IF DISCHARGED TO PROPOSED PLACEMENT.

❑ CHILD WILL NO LONGER BE ELIGIBLE FOR MEDICAID IF DISCHARGED TO PROPOSED PLACEMENT.

❑ ELIGIBILITY DETERMINATION COULD NOT BE COMPLETED DUE TO:_____

_____

ELIGIBILITY WORKER: _____ PHONE #: (_____)_____

DATE MAILED/FAXED: _____TO TRANSITIONAL SERVICES COORDINATOR.